COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
ALCOHOL AND DRUG PROGRAM ADMINISTRATION
COST REPORT FOR CONTRACTED SERVICES
FISCAL YEAR 2000-2001

SUMMARY PAGE
NON MEDI-CAL FUNDED

Type of Program : (Check One)

- ☐ Alcohol
- ☐ Drug
- ☐ Perinatal
- ☐ Parolee

PROPOSITION 36 USE ONLY

Type of Submission: (Check One)

- ☐ Original
- ☐ Amended

Contract Agency Legal Name: _____ D.B.A. _____

Contract Number: _____ Provider Number: _____ Contract term: From: _____ To: _____

Approved For Agency By: _____ Mode of Service: _____

Contact Person: _____ (Name) Telephone No.: _____ Program Capacity: _____

		(1) Actual Expenditures	(2) County Approved Budget	(3) (2)-(1) Variance
Program Expenses:				
1. Salaries & Employee Benefits	(Sch. P1)			
2. Facility Rent/Lease or Depreciation	(Sch. P2)			
3. Equipment and/or Other Asset Leases	(Sch. P3)			
4. Services, Supplies & Equip. Depreciation	(Sch. P4)			
5. Administrative Overhead	(Sch. P5)			
6. Total Gross Cost	(line 1-5)			
Less Revenue: (County Allocation Excluded)				
7. Participant/Client Fees				
8. Excess Fees Carryover from FY 1999/2000				
9. Excess Fees to be Carried Forward to FY 2001/		( )		
10. Private Funding/Public Assistance/Other Provider Revenue				
11. Total Revenue	**(line 7-10)**			
12. NET COST	**(line 6 less 11)**			
13. Total Units of Service Provided (Mandatory*)				
13a. Staff Hours				
13b. Clients Served				
13c. Visit Days				
13d. Slot Days				
13e. Bed Days				
14. Gross Cost Per Unit	**(line 6 divided by line 13a-e whichever is applicable)**			
15. Net Cost Per Unit	**(line 12 divided by line 13a-e whichever is applicable)**			

16.

Other Services	UOS	# Clients	Amount
Literacy Training			
Family Counseling			
Vocational Training			
Other Client Services			

*** For all types of contracts including cost line-item con**

COUNTY USE ONLY

Type of Contract:

- ☐ Fee for Service
- ☐ Cost Reimbursement Provisional Rate
- ☐ Cost Reimbursement Non-Provisional Rate

Total Cost Report Settlement Per County

16. Maximum Contract Amount (Co. Alloc.) $ _____
17. Maximum Cost Subject to Reimburse _____
18. Less YTD Non Medi-Cal paid _____
19. Balance Due (County)/Provider $ _____

Reviewed by: _____ **Name** **Date**

Approved by: _____ **Authorized Signature** **Date**